CHAPTER 3
PROGRAM SERVICES

3.1 Introduction

This chapter provides a synopsis of major programmatic functions and responsibilities of the Community Health Nursing Program Contractors. This general summary is not intended to be an all-inclusive description of the Contractor responsibilities. More comprehensive detailed descriptions of these responsibilities are contained throughout this policy manual and in each Contractor's written contract with Arizona Department of Health Services (ADHS).

3.2 Program Responsibilities

Contractors shall:

A. Provide a home-based visitation program, which can include professional staff from community health nursing, early intervention, and social work.

B. Follow the standards, guidelines and policies and procedures of ADHS.

C. Provide administrative, supervisory and evaluative services within the contractor's organizational systems, based on the needs of the child/family.

D. Employ, train, supervise and evaluate sufficient and adequate staff and support services, i.e., community health nurses, social workers and/or early interventionists.

E. Ensure personnel assigned to provide home visitation services receive program approved orientation, on-going education and training.

F. Ensure that staff participate and meet the requirements of the Arizona Early Intervention Program (AzEIP) Professional Development System.

G. Be responsible for maintaining documentation of current license number, CPR certification, education, training and self-assessment reviews for each licensed team member.

H. Develop and implement a Family Service Plan (FSP) for each child/family receiving services through the home visitation program. The FSP is based on individual child/family resources, priorities and concerns and should reflect the plan and timelines for addressing identified needs.

I. Collaborate and coordinate with other community based agencies in order to offer comprehensive, family centered services and prevent duplication of service.

J. Provide and implement a plan for a continuous quality improvement process (CQI) for nursing services based on specific indicators (see chapter 8).

K. Submit written education or marketing materials prepared by the Contractor for Community Nursing Services to the ADHS CHN Program Manager for approval, prior to distribution of materials.

3.3 Eligibility Requirements (NICP Infants)

In order to be considered for participation, the following initial condition must be met:

The primary caregiver/ parent of the infant must reside in Arizona when eligibility is determined and throughout HRPP/NICP service delivery. A residential street address is sufficient to prove residence for HRPP/NICP purposes. A P.O. Box address is not acceptable.

Once the above conditions are met, the infant must meet one or more of the criteria below in order to be eligible for the NICP:

A. Infants who require 120 **hours or more** of Level II, II EQ or Level lII nursery care beginning within **96 hours of birth.** (Example: infant is discharged 24 hours after birth and is readmitted to NICU at 4 days of age with a neonatal condition that was present but not detected at birth.)

B. Infants approved for transport to a Program contracted hospital by a Program contracted neonatologist, if they subsequently require 120 hours of Level II, II EQ, or Level III nursery care..

C. Infants who require Level II, II EQ, or Level III nursery care and who subsequently expire after medical intervention has occurred are eligible.

D. Infants with special needs other than the above may be authorized for admission to the Program upon submission of a request from a Program contracted neonatologist. (This request may be made by signing and dating the *Request for Participation* and providing a brief reason for request. The name of the requesting neonatologist must be included on the form. The authorized hospital representative signature is still necessary). Neonatologist request does not guarantee enrollment into the HRPP/NICP. Each request will be evaluated to determine the needs of the infant and family as well as the most appropriate resource (HRPP/NICP, OCSHCN, CRS, AzEIP).

E. Any infant who was in a NICU in another state whose parents now reside in Arizona qualifies for HRPP/NICP follow-up services only.

F. Infants who do not meet the established criteria for HRPP/NICP may be eligible for Community Health Nursing services through the Office for Children with Special Health Care Needs (OCSHCN).

3.4 Enrollment (NICP Infants)

The appropriate ADHS contracted hospital enrolls an infant meeting the eligibility criteria described above. If an infant is inborn and eligible under criteria 3.3a above, HRPP/NICP forms must not be completed by hospitals prior to the determination of eligibility (i.e., 120 hours from the time of birth).

A. Each contract hospital shall have designated and trained personnel available to explain the Program to eligible families and assist them with enrollment. The HRPP/NICP requires that hospital personnel be responsible for completion of all forms required for enrollment.

B. Program enrollment is obtained by the completion of the HRPP/NICP Hospital Services *Request for Participation Form* or an approved ADHS substitute.

1. Designated hospital personnel shall interview families in order to complete the *Request for Participation Form, Financial Worksheet, and Financial Questionnaire.*
2. The contracted Level II, IIEQ or Level III hospital of birth is usually considered the enrolling hospital, provided that, the infant spends 120 hours in their intermediate or intensive care nursery. The enrolling hospital is required to complete and distribute **ALL** NICP forms.

a. If the infant is transported within the first 120 hours, the contracted **receiving** hospital will be considered the enrolling hospital, and is required to complete and distribute all of the NICP forms.
b. If the infant is transported **after** the first 120 hours, the contracted **birth** hospital is required to complete and distribute all of the NICP forms.

3. After initial enrollment into the NICP, if an infant is forward or back transported from one NICP contracted hospital to another, the referring facility initiates the process and completes as much of the *Request for Neonatal Transport* form as possible. The transport carrier(s) will complete the form and distribute all copies as indicated. The referring facility also completes and distributes the *Discharge Summary Form* to document the discharge.

   a. When an infant is transported from a non-contracted hospital to a contracted hospital, the transport team initiates the process by completing the *Request for Neonatal Transport* form. A signed and completed *Request for Neonatal Transport* form is required for **each** transport and is distributed by the transport carrier.
   b. The **parent's or legal guardian's signature** on the *Request for Neonatal Transport* form is obtained as consent to transport the infant. If the infant is transported and the *Request for Neonatal Transport* form is signed by the flight nurse because the infant must be transported immediately and a parent or guardian is not available, the transport nurse will print the parent's name, initial and date the entry, and write the reason the parent cannot sign. For back transports, **if the family is not available to sign the form, a telephone call with a *notation that consent was given via telephone* including the *name of the parent authorizing participation* and a hospital signature is sufficient.**
   c. **A witness signature is preferred when possible.**

C. The contracted enrolling hospitals submit to the HRPP/NICP: *Request for Participation Form*; *Financial Worksheet* and *Financial Questionnaire; and Hospital Discharge Summary Form* for each infant enrolled in the Program within the timelines specified in Chapter 6 of the Hospital and Physician Services Policy and Procedure Manual.

D. When families enroll they may request 1) **full** participation, which includes financial assistance, transport, medical care and follow-up

services; or 2) **partial** participation, which includes follow-up services only.

Enrolling hospitals must submit the Request for Participation so that HRPP/NICP receives the forms within HRPP/NICP timelines. Exceptions may be made in unusual circumstances, but will require prior authorization from the Hospital Services Program Manager. The enrolling hospital must provide documentation under the Late Enrollment section on the *Request for Participation form*. **Enrollment in the HRPP/NICP occurs when data forms are received and accepted as complete by ADHS, and within the established time frames.**

3.4.1 Late NICP Enrollment

a. An NICP Program Manager must authorize Requests for Participation in the Program, which occur beyond 30 days of the infant's birth. The *Request for Participation* form shall be submitted to the appropriate NICP Manager with a completed *Request for Late Enrollment*, *Request for Participation* and any other supporting documentation such as a Discharge Summary Form. An exception to this might occur when a hospital did not sign the family up for the Program and the CHN is asked to do so. This would usually occur within a few days after the infant is discharged. The CHN should not complete the *Financial Questionnaire* but refer the family to the NICP Claims Coordinator at 602-364-1432.

b. The NICP Contract Providers requesting authorization for late enrollment shall assist the family in completing the Request for Participation. Families who are requesting late enrollment are eligible for follow-up services only and are not eligible to receive financial assistance for transport or hospital services**.**

c. The appropriate NICP manager will notify the community health nurse or contracting hospital of any requests that are denied.

3.4.2 Adoption and Foster Care

a. When an infant is to be placed in foster care, either the birth parent or representative from the guardian agency may sign the *Request for Participation Form*. If the infant is in the care, custody, and control of DES, the family liability would be zero.

b. When a child is to be adopted but the date of the consent to adopt has not been provided by the birth parent(s), adoption agency or attorney, they may enroll the infant in the HRPP/NICP and must

apply for AHCCCS or enroll the infant in other third party insurance if eligible. If the birth family has no insurance and is denied AHCCCS eligibility, the family liability shall be zero.

c. If there is consent to adopt but no adoptive parents are identified, the birth parent(s) must apply for AHCCCS or enroll the infant in other third party insurance if eligible. The birth family's resources may be used but the family liability will be zero.

d. If the birth parent(s) have provided the date of consent to adopt, then the date of the consent will be the date that the financial liability using the adoptive parents' income will commence. The adoptive family may then enroll the infant in the HRPP/NICP. The adoptive family must apply for AHCCCS or enroll the infant in other third party insurance if eligible. If the adoptive family completes the *Financial Questionnaire*, they must also sign a *Request for Participation Form*, even if the birth parent has already enrolled the infant.

3.5 Eligibility Requirements for Children with Special Health Care Needs (CSHCN): Infants/Toddlers/Children

Eligible individuals shall reside in Arizona. These infants and children may have been born without incident but later developed health and/or developmental delays and meet one or more of the following criteria:

A. Infants/toddlers not enrolled in NICP who have a chronic medical condition and whose families demonstrate a need for information, support, and/or coordination with multiple service providers and resources. This would include children from 0-3 years of age and 3-21 as authorized by the Community Nursing Services Program Manager.

B. Children 0-3 who meet eligibility requirements for AzEIP services and need medical support as determined by the Individual Family Service Plan (IFSP).

C. Children 0-3 who do not meet AzEIP, DDD or ASDB eligibility but exhibit developmental delay.

3.6 Enrollment Requirements for Children with Special Health Care Needs: Infants and Children

Infants and children meeting eligibility requirements may be enrolled as children with special health care needs (CSHCN) and be referred for Community Nursing Services.

A. Referrals of eligible children may be made directly to Community Health Nurse (CHN) who, upon family request and permission, will complete the *Children with Special Health Care Needs Request for Participation in the Community Health Nursing Program* form with the family.

B. For infants not eligible for NICP, hospital NICU or Pediatrics staff will complete the *Children with Special Health Care Needs Request for Participation in the Community Health Nursing Program* with the family and send it to the appropriate CHN.

C. The *Request for Participation* form will be sent to the ADHS Community Health Nurse Program Manager with monthly billings.

D. The Resiliency and Risk Identification System for Children (RRISC)© may be completed for infants/children to assist the family and nurse in identifying concerns, priorities and levels of service need. The CHN shall also assist families with referrals to other service systems or providers (such as AzEIP Interim Service Coordinators) as indicated.

3.7 Collaboration

An essential component of community nursing services is the collaboration with hospitals, primary care providers, and other agencies to assist infants and children and their families in accessing appropriate services. Community Nursing providers are expected to:

A. Attend hospital discharge planning meetings at Level IIEQ or Level III hospitals within their service area. In areas with multiple nursing contractors and hospitals, one or two nurses shall attend discharge planning meetings and provide information to the individual nurses responsible for visiting those families discharged into their service area. Independent and specialty contractors may share responsibility for attending discharge planning meetings. Nurses attending those meetings must also document pertinent information on the form provided by ADHS to assist CHN's in providing better services to families.

B. Meet with Level IIEQ and Level III hospital personnel to:

1. Develop a collaborative relationship
2. Receive discharge information
3. Provide feedback to hospital personnel

4. Provide training on NICP and other community resources as appropriate

C. Attend multi-disciplinary staffing meetings as requested by agencies and/or families. These may include:

1. Hospital discharge staffing
2. Child protective services staffing
3. Individual Family Service Plan (IFSP) meeting
4. DDD, OCSHCN, CRS or ASDB staffing
5. Other staffing as appropriate

CHNs will, as is appropriate, be part of an infants IFSP team and work collaboratively with all other team members. This will include, at a minimum, sharing any results, findings related to the infant's health and well-being. Sharing of information may be at a staff meeting, by fax, by phone, or any other forum, once permission to share information has been retrieved from the parent/guardian.

3.7.1 Discharge Planning

The following policies and procedures regarding discharge planning were incorporated in both the hospital and community nursing policy and procedure manuals in order to promote continuity. Therefore, policies pertinent to hospitals only may be included, letting each CHN know policies and procedures the contracted hospitals are responsible for.

Each hospital and nursing contractor is required to provide comprehensive, family-centered discharge planning for each enrolled infant in accordance with the HRPP/NICP Discharge Planning Guidelines as follows:

a. Infants enrolled in HRPP/NICP shall:

i. Receive comprehensive discharge planning initiated on admission and based on ADHS Discharge Planning Guidelines.

ii. Continue to receive HRPP/NICP services when transferred to special care units within the same hospital. The *Hospital Discharge Summary Form* shall be transferred with the infant and sent to the HRPP/NICP Data Manager when discharged from each hospital.

iii. Be entitled to the same HRPP/NICP services when placed into foster care or adoption. Hospital personnel shall be responsible for notifying and informing the responsible agency and/or family regarding the array of services available.

b. Contracted hospitals and CHN's shall ensure that the HRPP/NICP forms are completed and maintained as follows:

i. A Discharge Planning notebook will be kept in a specific nursery unit location to maintain and organize the *Request for Participation* and *Hospital Discharge Summary Forms* until infant's discharge.

ii. All CHN contractors providing services in an area where there is a Level II EQ and III hospital shall participate in the formal discharge planning processes. The CHN attending these discharge planning meetings shall assist the hospital discharge coordinator to ensure that information is recorded on all copies of the *Hospital Discharge Summary Form*. The CHN shall also note any pertinent information on the discharge notes sheet for the CHN who will be providing follow-up services. These notes shall be kept in the Discharge Planning notebook with the NICP forms and updated by the CHN at each Discharge Planning meeting. These notes will be sent by the discharging hospital to the CHN providing follow-up services, on the day of the infant's discharge.

iii. In areas where multiple Level II, II EQ and III hospitals and CHN contractors exist, it will be the responsibility of the CHN's to meet on a regular basis to determine which nurses will visit which hospitals to assist with the discharge planning process.

iv. Each CHN shall be responsible for maintaining ongoing collaboration with at least one level II and/or level I hospital to facilitate the discharge planning process. These hospitals are required to maintain a Discharge Planning notebook as described above.

c. All enrolled infants are referred to Community Nursing Services. Contracted hospitals shall ensure that the completed forms will be distributed as follows:

i. **Level II EQ and III (local):** The yellow copy of the *Request for Participation Form* (if baby is inborn, Xeroxed copy if transported) shall be distributed to the CHN(s) attending weekly discharge planning meetings for all Level II, II EQ and Level III hospitals. The CHN taking the forms will be responsible for distributing them within 7 days to the appropriate CHN for follow-up. The yellow copy of the *Hospital Discharge Summary Form* and the nursing notes sheets will be faxed to the appropriate Community Nursing Contractor on the infant's discharge date.

ii. **Level II EQ and III (non-local):** The yellow copy of the *Request for Participation Form* (if baby is inborn, Xeroxed copy if transported) and shall be faxed to the appropriate Community Nursing Agency immediately upon form completion**.** The yellow copy of the *Hospital Discharge Summary Form* and any nursing notes shall be faxed to the appropriate CHN on the day of infant discharge to facilitate continuity of care and initiate nursing home visits.

iii. **Level II:** The yellow copy of the Request for Participation Form shall be faxed by the hospital to the appropriate CHN immediately upon form completion**.** The yellow copy of the Hospital Discharge Summary Form shall be faxed to the appropriate CHN on the day of the infants discharge.

iv. **Level I:** Contracted nursing personnel providing services in an area with a level I hospital shall establish a collaborative relationship with that hospital to:

- Receive discharge information for babies needing OCSHCN follow-up
- Provide feedback to hospital personnel
- Provide training on NICP and other community resources as appropriate

d. Contracted hospitals shall be responsible for assessing the child's medical risk at the time of discharge. (The HRPP Medical Risk Criteria is located at the end of this section). Infants who meet high risk criteria are infants who have at least one of the major risk factors or have two or more minor risk factors. All Program infants regardless of risk criteria are eligible for Community Nursing follow-up and will be prioritized according to the needs of the child and family.

e. Contracted hospitals shall be responsible for ensuring accurate demographic data and other relevant information is documented on the forms. All medical and social needs must be documented on the *Hospital Discharge Summary Form*. **If the address is a P. O. Box number, directions to the family's residence must accompany the form**. If an infant is medically fragile or other concerns exist, the hospital shall make a telephone call to the CHN and/or family regarding the HRPP/NICP. **The *Hospital Discharge Summary Form* must be faxed with a note of urgency if a priority home visit needs to be completed.**

f. The most recent written developmental assessment and plan shall be given to the family and the community health nurse at time of discharge.

3.8 Home Visitation Services

The service planning process, while needing to hold participants accountable for decisions and actions, must also be flexible, coordinated and culturally sensitive to accommodate changes that occur within the family over time. Long term and future goals must be explored with the family as well as immediate needs or concerns. Home visiting services are based on health, development, environment and relationship risk. Risk can be determined through use of the "Resiliency and Risk Identification System for Children" (RRISC) © or other risk identification tool.

A. **CHN contact with the family shall occur within one week of discharge from the hospital.** Reasons for exceptions shall be documented on the *Community Nursing Follow-Up Assessment* (Visit form). Home visits must not occur if the CHN does not have a copy of the *Request for Participation* form for infants enrolled in the NICP. Enrollment for children with special health care needs may occur

during the first home visit upon completion of the *Children with Special Health Care Needs (OCSHCN) Request for Participation in the Community Health Nursing Program* form. The one week contact rule does not apply to OCSHCN enrollees.

B. If the parent does not wish to participate in the program, the nurse shall check the appropriate box on the Change of Status form and send the form in with the monthly invoice or on the visit form if family expressed that decision during a visit. Please do not send the information on a visit form if a home visit has not been completed. If a visit has been completed, there is no need to send a *Change of Status* form in addition to the visit form.

C. The community health nurse must perform the initial visit within two weeks after discharge and must provide case management for children having ongoing medical problems. Services might be delayed if there are other home providers or if parents request the CHN to begin visits at a later time. The social worker and/or early interventionist should be utilized to perform the most appropriate level of service based on the needs of the child and family.

   All initial home visits must be completed by a CHN, subsequent visits, if needed, could be conducted by a social worker, or other appropriate health professional (speech therapist, physical therapist, occupational therapist, dietician, etc), as determined by the needs of the infant and family. The CHN may or may not be present at these subsequent visits. If the CHN is present and provides a complete assessment of the child this visit would be a “regular” visit and two visit forms would be submitted; the first form by the CHN and the second form by the other attending health professional. That form should clearly state the professional’s area of expertise across the top of the form. Any other paperwork generated by this professional should be copied and sent to ADHS along with the monthly invoice. If no assessment is completed by the CHN; this would be a “staffing” visit.

D. The Community Health Nurse should transfer services to one of the following providers as quickly as is appropriate:

   - Health Start, Healthy Families, other NICP CHNs, DES/AzEIP, ADHS, DDD and ASDB Interim Service Coordinators, Early Head Start, etc.

E. Pre-discharge nursing visits may be completed prior to an infants discharge. **CHN’s are encouraged to complete pre-discharge visits at the hospital where they participate in discharge planning**

meetings, regardless of service area. Meeting with the family and hospital staff during the child's hospital stay is beneficial for helping parents to understand the program and for making that initial connection.

F. Based on discussions with the family, the home visitor will develop and implement a Family Service Plan (FSP), which identifies family resources, priorities and concerns.

The FSP could:

1. Identify child and family desired outcomes.
2. Explore the family's natural helping network, such as extended family members, friends or neighbors.
3. Explore child and family health insurance benefits and provide information about services available in the community.
4. Identify other agencies or services for which the child may be eligible, facilitate referrals, and enrollment.
5. Assist the family in identifying needed services as appropriate.

The FSP is developed during the first visit, and may be updated with each visit or as changes occur. The FSP should be signed by the family and the CHN.

The Family Service Plan is not a legal document, which means that services identified as needed are not required to be provided by the CHN program. Efforts shall be taken, however, to facilitate the referral of families to appropriate service providers, and encourage enrollment.

G. All NICP enrolled infants are identified upon discharge from the hospital as "high risk" or "at risk" for developmental delay. Families who have a child that is considered to be in the "high risk" category should be strongly encouraged to receive follow-up services through the Community Nursing Services component of the program. Infants who have an established condition at the time of discharge should be referred, by the discharging hospital, directly to the Division of Developmental Disabilities (DDD), or the Arizona Early Intervention Program(AzEIP). Established conditions that have a high probability of developmental delay include, but are not limited to:

- Chromosomal abnormalities
- Metabolic disorders
- Hydrocephalus
- Neural tube defects (e.g. spina bifida)
- Intraventricular hemorrhage, grade 3 or 4

- Periventricular leukomalacia
- Cerebral Palsy
- Significant auditory impairment
- Failure to thrive
- Severe attachment disorders

Determination that a child has an established condition will be based on diagnosis by a qualified physician or other qualified professional (e.g. audiologist) and medical records, and will include the use of informed clinical opinion. (34 CFR 303.300 State Eligibility Criteria and Procedures ARS 8-651-Definitions)

H. The NICP home visitor (CHN, Social Worker or Early Interventionist) may also refer the family to the Arizona Early Intervention Program (AzEIP). NICP families may be referred to AzEIP for further assessment for the following reasons:

1. "Suspicious" outcome after screening with the Ages and Stages Questionnaire

2. One or more "failures" or two or more "cautions" on the Denver Developmental II screening tool.

3. Neuromotor or behavioral condition concerns

4. Parental concern regarding the child's development that is unresolved after intervention by the Community Health Nurse or Early Interventionist.

Screening information should be shared with AzEIP team members in an effort to assist with eligibility determination, identification of medical concerns, continuity of care and reduction of duplicative services.

I. NICP and other children with special health care needs that require further services not provided by the CHN Program should be referred to the DES/AzEIP/IPP contractor, to begin the initial planning process. The DES/AzEIP will explain AzEIP services, complete needed paperwork, and refer the child and family for eligibility determination/ evaluation as needed.

Services provided by the CHN Program are part of the Arizona Early Intervention System. With appropriate release from the family (obtained at the first visit, information gathered, clinical impressions and the *Family Service Plan: Resources, Priorities and Concerns* may

be forwarded to the AzEIP as part of the continuum of early intervention services. The CHN documentation shall become part of the child's record. The CHN may assist the child and family in transitioning to the AzEIP, as appropriate and should do so as soon as it is medically appropriate.

J. Children with special health care needs over 3 years of age may be seen for developmental follow-up services through OCSHCN but must be authorized by the OCSHCN CHN Program Manager. (See contact list in Appendix)

K. The home visitation information shall be documented on the CHN Nursing visit form(see chapter 6). Both pages are filled out legibly and completely upon completion of the home visit and submitted to the Community Nursing Program Manager with the monthly log and invoice. Any information not on the "Request for Participation" form and all white areas must be filled out on the initial visit. Shaded areas do not need to be filled out on subsequent visits. The mother's name, child's alias, etc. must be filled out each time to facilitate data query. The Request for Participation and Family Service Plans are filed in the client's chart, and are subject to review at site audit.

L. Contractors participating in the Newborn Screening Follow-Up Program contact the families after a call from the Newborn Screening Hotline. The Community Health nurse will make a home visit and provide education about Newborn Screening and a follow up blood test. All procedures in the Newborn Screening Guidelines are to be followed. (Guidelines may be found at the end of this chapter.)

3.9 Guidelines for Case Closure

CHN's may close cases as follows:

A. Infants are over 12 months adjusted age and have no medical or developmental problems or are in services. (goals met/ service complete)

B. Infants are being seen by other service providers, medical intervention by a CHN is not necessary (Closed/discharged)

C. When risk at birth is unclear on the hospital forms, the CHN makes one or more home visits and determines the child and family to be in the lowest risk category. (NICP closed/low risk)

D. CHN makes contact with the family after home visitation has been established and the family states the visits are not needed. (Voluntary withdrawal)

E. Prior to home visits being established, the CHN makes contact with the family and they verbally refuse nurse home visitation. (Declined Nursing follow up/ initial contact)

F. When several attempts have been made to reach a family, such as a letter, phone call or home visit and there is no response. Phone is disconnected, mail undeliverable, family has left no forwarding address (Lost to Follow-up)

G. Moved out of State

H. Death include date of death

3.9.1 Guidelines for Closure When Families Meet Criteria for Visits but do not Respond

When a family cannot be physically located, i.e moved with no forwarding address or ability to be contacted by phone, they are considered **"**Lost to follow-up". The following are guidelines for documentation of closure to community nursing services.

a. When family and infant are lower risk:
   - CHN must make at least 2 contact attempts by phone or mail with no response.

b. When family and infant are moderate risk:
   - CHN must make at least 2 contact attempts by phone or mail. CHN will use clinical judgment to determine whether a drop in home visit needs to be made prior to closure.

c. When family and infant are highest risk:
   - CHN's must complete a drop in home visit and leave a NICP brochure or a hand written note and business card. The CHN may also leave a phone message or attempt to contact the family by mail.

3.9.2 Guidelines for transferring cases between ADHS/NICP contractors

(revised- to be effective 11/1/05)

When a family is moving out of one service area into another service area the CHN should ask the family if they are interested in continuing services in their new community. If so, the CHN should use the revised "enrollment status change form" to get the parent/guardian's signature for their permission to release information. Once received the change form should be submitted with the monthly billing **AND** a ***copy*** of the entire case file should be forwarded to the new CHN contractor (refer to the CHN directory for appropriate contractor, or call the Program Manager for verification)

3.10 Determining the level of risk

Utilizing the **Medical Risk Criteria Form** (see end of chapter for sample form) determine if the infant is "high risk" or "at risk". This should be determined by using the information contained in the discharge summary from the hospital.

Next the CHN will conduct the initial contact and home visit. During this initial visit the CHN will conduct a complete assessment of the child. The **Community Nursing Neonatal and Pediatric Assessment Form** (see end of chapter for sample) will be completed at this time.

Infants with major risk factors from **Medical Risk Criteria Form** will remain high risk. All other infants risk level will be determined as follows:

Two (or more) areas of concern in two (or more) categories from **Community Nursing Neonatal and Pediatric Assessment Form** are considered High risk.

One area of concern in two categories from **Community Nursing Neonatal and Pediatric Assessment Form** is considered Moderate Risk.

One area of concern in one category from **Community Nursing Neonatal and Pediatric Assessment Form** is considered low risk.

3.11 Minimum Visit Guidelines

The Olds model for home visitation of NICP infants recommends a frequent schedule of home visits. Once a week for the first six weeks, every other week until 21 months, and once a month from months 21-24. (David Olds, PH.D. Prenatal and Infancy Home Visitation By Nurses, 1998). Budget constraints prevent HRPP/NICP from following that model.

In FY 2007 the Arizona State Legislature awarded the High Risk Perinatal Program additional funds for the additional provision of services to at risk infants and families. These funds are provided so that all at risk infants enrolled in the NICP would have a minimum of four home visits during their first year of life. In FY 2009 that funding was reduced due to a budget reduction. CHN visit scheduling should prioritize visitation to ensure the infants are seen as appropriate according to their risk.

Additional visits are allowable based on the needs of the child and family, impressions of the CHN, or at the family's request, pending program funding, and must be well documented in the client chart.